STANDARD PLAN

Group Health Insurance

WISCONSIN GROUP INSURANCE BOARD

DEPARTMENT OF EMPLOYEE TRUST FUNDS
P. O. Box 7931
801 West Badger Road
Madison, Wisconsin 53707-7931

BlueCross & BlueShield
United of Wisconsin
An independent licensee of the Blue Cross
and Blue Shield Association

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Blue Cross Blue Shield United of Wisconsin administers the CONTRACT as of January 1, 2004.

In the event of a conflict between the CONTRACT and any applicable federal or state statute, administrative rule, or regulation; the statute, rule, or regulation will control.

GENERAL INFORMATION ABOUT YOUR PLAN

The STANDARD Group Health Insurance Plan is available to State of Wisconsin EMPLOYEES, ANNUITANTS, and their eligible DEPENDENTS, regardless of residence. The plan is administered by Blue Cross and Blue Shield United of Wisconsin (BCBSUW). See the back of this booklet for the address and telephone numbers of BCBSUW.

All services should be provided by a PREFERRED PROVIDER in order to result in the lowest out-of-pocket cost to you.

The Plan reserves the right to modify the list of PREFERRED PROVIDERS at any time, but will honor the selection of any provider listed in the current provider directory for the duration of that CONTRACT year unless that provider left the plan due to normal attrition (limited to, retirement, death or a move from the Plan Service Area or as a result of a formal disciplinary action for quality of care). A PARTICIPANT who is in her second or third trimester of pregnancy may continue to have access to her PREFERRED PROVIDER until the completion of post-partum care for herself and the infant.

Alternate health care plans are also available in specific limited geographical areas. Those plans are known as Health Maintenance Organizations (HMO's) and actually compete against the STANDARD PLAN in cost, service and benefit level. Before making an enrollment decision, all plans operating in your locality should be investigated so the PLAN most appropriate to your needs is selected.

This booklet is devoted to STANDARD PLAN BENEFITS. Other information of which you must also be aware, is contained in a brochure titled It's Your Choice. That brochure compares BENEFITS of STANDARD, SMP and all available HMO's and covers the following topics:

- Cancellation
- Change in family status
- Claims
- Complaint process
- Conversion
- Continuation of coverage after loss of eligibility
- Coordination of Benefits
- Coverages
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- Leave of Absence
- Payroll Deductions
- Pharmacy Benefit Manager
- Retirement
- State Contribution toward premium
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DEFINITIONS

There are a number of important terms which have special meaning when they are used in the CONTRACT and in this handbook. The most important of these terms and their definitions are listed here.

ADVANTAGE PROGRAM means the program of comprehensive utilization management, including pre-certification, admission review, concurrent review, discharge planning and case management.

ADVERSE DETERMINATION means a determination that involves all of the following:

1. BCBSUW reviewed an admission to, or continued stay in, a health care facility, the availability of care, or other treatment that is described as a Covered Service;
2. Based on the information provided, BCBSUW determined that the treatment does not meet BCBSUW requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness;
3. As a result, BCBSUW reduced, denied, or terminated benefits for the treatment.

ANNUITANT means any retired EMPLOYEE of the State of Wisconsin: receiving an immediate annuity under the Wisconsin Retirement System; or an EMPLOYEE with 20 years of creditable service or a disability benefit under Wis. Stats. § 40.65.

BENEFIT PERIOD means the total duration of CONFINEMENTS that are separated from each other by less than 365 days.

BENEFITS means payments for HOSPITAL SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES.

BIOLOGICALS means complex substances or products of organic or synthetic origin, other than food, depending for their action on the processes effecting immunity when used in immunization against or diagnosis and treatment of disease or obtained or standardized by biological methods. Some examples are vaccines, serums, antigens or insulin.

Definitions (cont.)

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN (BCBSUW) means a service insurance corporation organized under Chapter 613 of the Wisconsin State Statutes. For the purpose of the administration of the CONTRACT, BCBSUW is the agent of the BOARD. BCBSUW acts as health claim administrator under the terms of an Administrative Services Agreement with the State of Wisconsin.

BOARD means the Group Insurance Board.

BONE MARROW TRANSPLANTATION means the mixing of blood and bone marrow from a PARTICIPANT or a compatible donor by means of multiple bone punctures performed under anesthesia and transplanted to the recipient.

CALENDAR YEAR means the period that starts with a PARTICIPANT'S initial EFFECTIVE DATE of coverage under the CONTRACT and ends on December 31 of such year. Each following CALENDAR YEAR shall start on January 1 of any year and end on December 31 of that year.

CHARGE means an amount for a service or supply provided by a health care provider that is reasonable, as determined by BCBSUW, when taking into consideration, among other factors determined by BCBSUW, amounts charged by health care providers for similar SERVICES and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care provider as full payment for similar SERVICES and supplies. In some cases the amount BCBSUW determines as reasonable may be less than the amount billed. CHARGES for HOSPITAL or other institutional CONFINEMENTS are incurred on the date of admission. All others are incurred on the date the PARTICIPANT receives the service or supply. CHARGE includes all taxes for which a SUBSCRIBER can legally be charged, including but not limited to, sales tax.

COINSURANCE means a portion of the CHARGE for BENEFITS for which the PARTICIPANT is responsible. COINSURANCE will not be reduced by refunds, rebates, or any other form of negotiated post-payment.

Definitions (cont.)

COMPLICATION OF PREGNANCY means a condition needing medical treatment before or after termination of pregnancy. The condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis; cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct COMPLICATION OF PREGNANCY but are connected with management of a difficult pregnancy. Also included are: terminated ectopic pregnancy, spontaneous termination that occurs during a pregnancy in which a viable birth is impossible, hyperemesis gravidarium, and preeclampsia.

CONFINEMENT means the period starting with a PARTICIPANT'S admission on an INPATIENT basis to a GENERAL HOSPITAL, SPECIALTY HOSPITAL, LICENSED SKILLED NURSING FACILITY or EXTENDED CARE FACILITY for treatment of an ILLNESS or INJURY. CONFINEMENT ends with the PARTICIPANT'S discharge from the same HOSPITAL or other facility.

CONGENITAL means a condition which exists at birth but is not hereditary.

CONTRACT means the Group Master Administrative Services Only Contract between the BOARD and Blue Cross and Blue Shield United of Wisconsin.

CUSTODIAL CARE means the type of care which is designed essentially to assist a person to meet activities of daily living. It does not entail or require the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. CUSTODIAL CARE includes those SERVICES which constitute personal care such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may still be custodial even though such care involves the use of technical medical skills if such skills can be easily taught to a layperson. Provision of room and board, nursing care, personal care or other care designed to assist an individual who, in the opinion of a plan physician, has reached the maximum level of recovery. CUSTODIAL CARE is provided to PARTICIPANTS who need a protected, monitored and/or controlled environment or who need help to support the essentials of daily living. CUSTODIAL CARE also includes rest cures, respite care, and HOME CARE provided by family members.

Definitions (cont.)

DEDUCTIBLE means a fixed dollar amount the PARTICIPANT must pay before the HEALTH BENEFIT PLAN will begin paying the CHARGES for BENEFITS.

DEPARTMENT means the Department of Employee Trust Funds.

DEPENDENT means the spouse of the SUBSCRIBER and his or her unmarried children (including legal wards who become legal wards of the SUBSCRIBER prior to age 19, but not temporary wards, adopted children or children placed for adoption as provided for in Wis. Stats.§ 632.896, and stepchildren), who are DEPENDENT on the SUBSCRIBER (or the other parent) for at least 50% of their support and maintenance and meet the support tests as a DEPENDENT for federal income tax purposes (whether or not the child is claimed), and children of those DEPENDENT children until the end of the month in which the DEPENDENT child turns age 18. Children born outside of marriage become DEPENDENTS of the father on the date of the court order declaring paternity or on the date the acknowledgment of paternity is filed with the Department of Health and Family Services or equivalent if the birth was outside the State of Wisconsin. The EFFECTIVE DATE of coverage will be the date of birth if a statement of paternity is filed within 60 days of the birth. A spouse and stepchildren cease to be DEPENDENTS at the end of the month in which a divorce decree is entered. Wards cease to be DEPENDENTS at the end of the month in which they cease to be wards. Other children cease to be DEPENDENTS at the end of the CALENDAR YEAR in which they turn 19 years of age or cease to be DEPENDENT for support and maintenance, or at the end of the month in which they marry, whichever occurs first, except that:

a. Children age 19 or over who are full-time students, if otherwise eligible, cease to be DEPENDENTS at the end of the CALENDAR YEAR in which they cease to be full-time students or in which they turn age 25, whichever occurs first.

Definitions (cont.)

b. Student status includes any intervening vacation period if the child continues to be a full-time student. Student means a person who is enrolled in and attending an institution which provides a schedule of courses or classes and whose principal activity is the procurement of an education. Full-time status is defined by the institution in which the student is enrolled. Per the Internal Revenue Code, the term "school" includes elementary schools, junior and senior high schools, colleges, universities, and technical, trade, and mechanical schools. It does not include on-the-job training courses, correspondence schools, intercession courses and night schools.

c. If otherwise eligible children are, or become, incapable of self-support on account of a physical or mental disability which can be expected to be of long-continued or indefinite duration, they continue to be or resume their status of DEPENDENTS regardless of age or student status, so long as they remain so disabled. The child must have been previously covered as an eligible DEPENDENT under this program in order to resume coverage. The plan will monitor mental or physical disability at least annually and will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the initial plan determination.

d. A child who is considered a DEPENDENT ceases to be a DEPENDENT on the date the child becomes insured as an eligible EMPLOYEE.

e. Any DEPENDENT eligible for BENEFITS will be provided BENEFITS based on the date of eligibility, not on the date of notification to the plan.

DURABLE MEDICAL EQUIPMENT means an item which can withstand repeated use and is, as determined by BCBSUW:

a. primarily used to serve a medical purpose with respect to an ILLNESS or INJURY;

b. generally not useful to a person in the absence of an ILLNESS or INJURY;

c. appropriate for use in the PARTICIPANT'S home; and

d. prescribed by a PHYSICIAN.

All requirements of this definition must be satisfied before an item can be considered to be DURABLE MEDICAL EQUIPMENT.

Definitions (cont.)

EFFECTIVE DATE means the date, as certified by the DEPARTMENT and shown on the records of the PLAN in which the PARTICIPANT becomes enrolled and entitled to the BENEFITS specified in this CONTRACT.

EMERGENCY means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a reasonably prudent layperson to reasonably conclude that a lack of medical attention will likely result in any of the following:

1. Serious jeopardy to the Participant's health. With respect to a pregnant woman, it includes serious jeopardy to the unborn child.
2. Serious impairment to the Participant's bodily functions.
3. Serious dysfunction of one or more of the Participant's body organs or parts.

EMPLOYEE means an eligible EMPLOYEE of the State of Wisconsin as defined under Wis. Stats. § 40.02 (25), or an eligible EMPLOYEE as defined under Wis. Stats. § 40.02 (46) or 40.19 (4) (a), of an EMPLOYER as defined under Wis. Stats. § 40.02 (28), other than the state, which has acted under Wis. Stats. § 40.51 (7), to make health care coverage available to its EMPLOYEES.

EMPLOYER means the employing state agency or participating local government.

EXPEDITED GRIEVANCE means a grievance where any of the following applies:

(a) the duration of the standard resolution process will result in serious jeopardy to the life or health of the SUBSCRIBER or the ability of the SUBSCRIBER to regain maximum function.

(b) in the opinion of the physician with knowledge of the SUBSCRIBER'S medical condition, the insured is subject to severe pain that cannot be adequately managed without the care of treatment as an EXPEDITED GRIEVANCE.

(c) a physician with knowledge of the SUBSCRIBER'S medical condition determines that the grievance shall be treated as an EXPEDITED GRIEVANCE.

EXPEDITED REVIEW means a situation where the standard External Review process would jeopardize the SUBSCRIBER'S life, health, or ability to regain maximum function.

Definitions (cont.)

EXPERIMENTAL/INVESTIGATIVE means the use of any service, treatment, procedure, facility, equipment, drug, device or supply for a PARTICIPANT'S ILLNESS or INJURY, as determined by BCBSUW:

a. requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or

b. isn't yet recognized as acceptable medical practice to treat that ILLNESS or INJURY, as determined by BCBSUW.

c. The criteria that BCBSUW uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be EXPERIMENTAL/INVESTIGATIVE include, but are not limited to:

    1) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis;

    2) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that ILLNESS or INJURY by the medical profession in the United States;

    3) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply;

    4) whether other, more conventional methods of treating the ILLNESS or INJURY have been exhausted by the PARTICIPANT;

    5) whether the service, treatment, procedure, facility, equipment, drug, device or supply is MEDICALLY NECESSARY;

    6) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by MEDICARE, Medicaid and other insurers and self-funded plans.

EXTENDED CARE FACILITY means a convalescent or chronic disease facility, whether operated independently or as a part of a GENERAL HOSPITAL which is accredited by the Joint Commission on Accreditation of Hospitals, or is recognized as an EXTENDED CARE FACILITY under MEDICARE or which is a nursing home as defined in Wis. Stats. § 50.01

Definitions (cont.)

(3). The term excludes facilities providing SERVICES primarily for custodial or domiciliary care or for the care of drug addiction or alcoholism.

EXTERNAL REVIEW means a review of BCBSUW's decision conducted by an INDEPENDENT REVIEW ORGANIZATION.

FAMILY SUBSCRIBER means a SUBSCRIBER who is enrolled for family coverage and whose DEPENDENTS are thus eligible for BENEFITS.

GENERAL HOSPITAL means an institution which is licensed as a HOSPITAL which is accredited by the Joint Commission on Accreditation of Hospitals providing 24 hour continuous service to confined patients. Its chief function must be to provide diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured or sick persons. A professional staff of PHYSICIANS and surgeons must provide or supervise its SERVICES. It must provide GENERAL HOSPITAL and major surgical facilities and SERVICES. It can't be:

(a.) a convalescent or EXTENDED CARE FACILITY unit within or affiliated with the HOSPITAL;

(b.) a clinic;

(c.) a nursing, rest or convalescent home, or EXTENDED CARE FACILITY;

(d.) an institution operated mainly for care of the aged or for treatment of mental disease, drug addiction or alcoholism; or

(e.) a health resort, spa or sanitarium.

GRAFTING means the implanting or transplanting of any tissue or organ.

GRIEVANCE means any dissatisfaction with the provision of BCBSUW's SERVICES or claims practices that is expressed in writing to us by, or on behalf of, the SUBCRIBER.

HEALTH BENEFIT PLAN means the part of this CONTRACT that provides BENEFITS for health care expenses, as described in Sections I through XVI in the State of Wisconsin Group Insurance Board Health Benefit Plan.

Definitions (cont.)

HOME CARE means a program providing HOME CARE SERVICES to a PARTICIPANT after discharge from CONFINEMENT in a HOSPITAL, as a substitute for CONFINEMENT. It means a program participated in by BCBSUW, the attending PHYSICIANS, various visiting nurse associations and/or organizations and various hospitals to make HOME CARE SERVICES available to PARTICIPANTS, who may, in the judgment of the PARTICIPANT'S PHYSICIAN, be discharged from CONFINEMENT earlier than would otherwise be medically advisable. The HOME CARE SERVICES must be provided or coordinated by a state licensed or MEDICARE certified home health agency or certified rehabilitation agency.

HOSPICE CARE means SERVICES provided to a terminally ill PARTICIPANT outside of a HOSPITAL or EXTENDED CARE FACILITY in order to ease pain and to make a PARTICIPANT as comfortable as possible. HOSPICE CARE SERVICES must be provided by or coordinated by a MEDICARE certified HOSPICE CARE facility under a HOSPICE CARE program.

HOSPITAL means a GENERAL HOSPITAL, as defined above.

HOSPITAL SERVICES means ROOM ACCOMMODATIONS and all SERVICES, equipment, medications and supplies that are furnished, provided by and used in the HOSPITAL, SPECIALTY HOSPITAL or EXTENDED CARE FACILITY to which the PARTICIPANT is admitted as a registered patient.

ILLNESS means a bodily disorder, disease, pregnancy, COMPLICATION OF PREGNANCY or NERVOUS OR MENTAL DISORDER. All ILLNESS existing simultaneously are considered one ILLNESS. Successive periods of ILLNESS due to the same or related causes are considered one ILLNESS. An ILLNESS is deemed terminated:

(a.) in the case of a SUBSCRIBER, upon the resumption of all duties of his/her occupation on a full time basis for at least 30 consecutive days.

(b.) in the case of a DEPENDENT, upon the resumption in full of normal activities for at least 30 consecutive days.

(c.) in any event, when, after a PARTICIPANT receives any medical or HOSPITAL treatment or care (whether or not payable under the CONTRACT), a period of at least 30 consecutive days intervenes before the PARTICIPANT again receives treatment or care.

Definitions (cont.)

IMMEDIATE FAMILY means the SUBSCRIBER'S spouse, children, parents, grandparents, brothers and sisters and their own spouses.

IMPLANTATION means the insertion of an organ, tissue, prosthetic or other device in the body.

INDEPENDENT REVIEW ORGANIZATION means an entity approved by the Office of the Commissioner of Insurance to review BCBSUW's decisions.

INJURY means bodily damage caused by an accident. The bodily damage must result from the accident directly and independently of all other causes.

INPATIENT means a PARTICIPANT admitted as a bed patient to a health care facility.

LAYOFF means the same as "leave of absence" as defined under Wis. Stats. § 40.02 (40).

LICENSED SKILLED NURSING FACILITY means a skilled nursing facility licensed as a skilled nursing facility by the state in which it is located. The facility must be staffed, maintained and equipped to provide these skilled nursing SERVICES continuously: observation and assessment; care; restorative and activity programs. These must be under professional direction and medical supervision as needed.

MAINTENANCE THERAPY means ongoing therapy delivered after the acute phase of an ILLNESS has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "Maintenance Therapy" is made by BCBSUW after reviewing an individual's case history or treatment plan submitted by a provider.

MATERNITY SERVICES means PROFESSIONAL SERVICES for pre- and post-natal care. This includes: laboratory procedures; delivery of the newborn; caesarean sections; and care for miscarriages.

MEDICALLY NECESSARY means a service, treatment, procedure, equipment, drug, device or supply provided by a HOSPITAL, PHYSICIAN or other health care provider that is required to identify or treat a PARTICIPANT'S ILLNESS or INJURY and which is, as determined by BCBSUW:

Definitions (cont.)

(a.) consistent with the symptom(s) or diagnosis and treatment of the PARTICIPANT'S ILLNESS or INJURY;

(b.) appropriate under the standards of acceptable medical practice to treat that ILLNESS or INJURY and of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures;

(c.) not solely for the convenience of the PARTICIPANT, PHYSICIAN, HOSPITAL or other health care provider; and

(d.) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the PARTICIPANT and accomplishes the desired end result in the most economical manner.

The fact that a PHYSICIAN or OTHER PROVIDER has prescribed, ordered, or recommended or approved a treatment, service or supply does not in itself make it MEDICALLY NECESSARY or otherwise eligible for payment .

MEDICAL SERVICES means PROFESSIONAL SERVICES recognized by doctors of medicine in the treatment of ILLNESS or INJURY. Not included are: MATERNITY SERVICES; surgery; anesthesiology; pathology; and radiology.

MEDICAL SUPPLIES means items which are:

(a.) primarily used to treat an ILLNESS or INJURY;

(b.) generally not useful to a person in the absence of an ILLNESS or INJURY;

(c.) the most appropriate items which can safely be provided to a PARTICIPANT and accomplish the desired end result in the most economical manner; and

(d.) prescribed by a PHYSICIAN. The item's primary function must not be for comfort or convenience.

MEDICARE means BENEFITS available under Title XVIII of the Social Security Act of 1965, as amended.

NERVOUS OR MENTAL DISORDER means any condition classified as a neurosis, psychoneurosis, psychopathy or psychosis.

NON-PREFERRED PROVIDER means a PROVIDER who does not meet the definition of PREFERRED PROVIDER.

Definitions (cont.)

ORAL SURGERY means an operative procedure to correct a problem in the oral cavity.

OTHER COVERAGE means any group or franchise CONTRACT, policy, plan or program of prepaid service care or insurance arranged through any EMPLOYER, trustee, union or association including, but not limited to, disability, health and accident or sickness care coverage, or the medical payments provisions of an automobile insurance policy, any or all of which would provide BENEFITS for medical care of any nature either on a service or expense incurred basis if the CONTRACT was not in effect.

OTHER PROVIDER means a person or facility other than a PHYSICIAN or HOSPITAL who or which is licensed, where required, to render SERVICES which are specific as BENEFITS under this CONTRACT. OTHER PROVIDERS include:

1. FACILITY OTHER PROVIDER - a facility primarily engaged in providing speciality SERVICES.

FACILITY OTHER PROVIDER includes:

a. Ambulatory Surgical Facility

b. Freestanding Dialysis facility

c. Independent Laboratory

A FACILITY OTHER PROVIDER not listed above requires BCBSUW'S prior written approval. BCBSUW considers the facility's SERVICES, affiliations, ownership, and accreditation and the PROVIDER'S furnishing care in the facility.

2. PROFESSIONAL OTHER PROVIDER - a person or other practitioner listed below. He or she must practice within the limits of law, which apply to his or her profession.

a. Cardiac Rehabilitation specialist

b. Certified Operating Room Technician - when SERVICES are supervised and billed for by an employer M.D. for surgical assistance only.

c. Certified Registered Nurse Anesthetist

d. Clinical Psychologist

e. Licensed Practical Nurse (LPN) - when SERVICES are supervised and billed for by an employer M.D.

f. Nurse Practitioner

Definitions (cont.)

g. Occupational Therapist

h. Operating Room Technician - when SERVICES are supervised and billed for by an employer M.D.

i. Physician's Assistant - where SERVICES are supervised and billed for by an employer M.D.

j. Physical Therapist

k. Registered Nursing (RN) - when SERVICES are supervised and billed for by an employer M.D.

l. Speech Language Pathologist

OTHER SERVICES means those SERVICES, if any, specified in the CONTRACT other than HOSPITAL SERVICES and PROFESSIONAL SERVICES.

OUT-OF-POCKET LIMIT means the total amount of DEDUCTIBLE and COINSURANCE that a PARTICIPANT must pay each CALENDAR YEAR.

OUTPATIENT means a PARTICIPANT who is admitted as a non-bed patient to receive HOSPITAL SERVICES.

PARTICIPANT means the SUBSCRIBER or any of the SUBSCRIBER's DEPENDENTS who have been specified by the DEPARTMENT to the plan for enrollment and are entitled to BENEFITS.

PHYSICIAN means a licensed medical doctor or surgeon. When required by law to cover the SERVICES of any other licensed medical professional under the CONTRACT, a PHYSICIAN also includes such other licensed medical professional (for example, a chiropodist, podiatrist, dentist or chiropractor) who:

(a.) is acting within the lawful scope of his/her license; and

(b.) performs a service which would be payable under the CONTRACT.

POSTOPERATIVE CARE means the medical observation and care of a PARTICIPANT necessary for recovery from a covered surgical procedure and received within 30 days following the date of surgery. Medical observation and care received by the PARTICIPANT after this 30 day period ends is not POSTOPERATIVE CARE.

PRE-EXISTING CONDITION means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date.

Definitions (cont.)

PREFERRED PROVIDER means a PROVIDER who has agreed in writing by executing a participation agreement with BCBSUW to provide, prescribe or direct health care SERVICES, supplies or other items covered under the policy to PARTICIPANTS. The provider's written participation agreement must be in force at the time such SERVICES, supplies or other items covered under the policy are provided to a PARTICIPANT. The Plan agrees to give PARTICIPANTS lists of PREFERRED PROVIDERS.

PREOPERATIVE CARE means the medical evaluation of a PARTICIPANT prior to a covered surgical procedure. It is the immediate preoperative visit in the HOSPITAL or elsewhere necessary for the physical examination of the PARTICIPANT, the review of the PARTICIPANT'S medical history and the assessment of laboratory, x-ray and other diagnostic studies. It does not include other procedures done prior to the covered surgical procedure.

PROFESSIONAL SERVICES means SERVICES provided by a PHYSICIAN of the PARTICIPANT'S choice to treat his/her ILLNESS or INJURY. Such SERVICES include SERVICES provided by a registered or licensed practical nurse, laboratory/x-ray technician and physician assistant provided such person is lawfully employed by the supervising PHYSICIAN or the facility where the service is provided, and he/she provides an integral part of the supervising PHYSICIAN'S PROFESSIONAL SERVICES while the PHYSICIAN is present in the facility where the service is provided. With respect to such SERVICES provided by a registered nurse or licensed practical nurse, laboratory/x-ray technician and physician assistant, such SERVICES must be billed by the supervising PHYSICIAN or the facility where the service is provided.

ROOM ACCOMMODATIONS means bed and room including nursery care, meals and dietary SERVICES and general nursing SERVICES provided to an INPATIENT.

SERVICES means HOSPITAL SERVICES, MATERNITY SERVICES, MEDICAL SERVICES, OTHER SERVICES AND PROFESSIONAL SERVICES and SURGICAL SERVICES.

SKILLED NURSING CARE means care furnished on a PHYSICIAN'S orders which requires the skills of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of these personnel.

SMP means State Maintenance Plan

Definitions (cont.)

SPECIALTY HOSPITAL means a short-term SPECIALTY HOSPITAL approved by BCBSUW and the State, licensed and accepted by the appropriate state or regulatory agency to provide diagnostic SERVICES and treatment for patients who have specified medical conditions. Such short-term SPECIALTY HOSPITALS include, for example, psychiatric, alcoholism and drug abuse, orthopedic and rehabilitative hospitals.

STANDARD PLAN means the CONTRACT excluding SMP, WISCONSIN PUBLIC EMPLOYERS and Medicare Plus $100,000 coverage.

SUBSCRIBER means an EMPLOYEE, ANNUITANT, or his or her surviving DEPENDENTS, who have been specified by the DEPARTMENT to the plan for enrollment and who is entitled to BENEFITS.

SURGICAL SERVICES means an operative procedure performed by a PHYSICIAN and that is recognized by BCBSUW for treatment of an ILLNESS or INJURY. Such SERVICES must improve or restore bodily function. Such SERVICES include PREOPERATIVE CARE and POSTOPERATIVE CARE. Such SERVICES do not include the reversal of a sterilization procedure or MATERNITY SERVICES.

TRANSITIONAL TREATMENT ARRANGEMENTS means SERVICES more intensive than OUTPATIENT visits but less intensive than an overnight stay in the HOSPITAL. Most often, transitional care will be rendered in a day treatment program that provides successive hours of therapy.

BCBSUW covers transitional SERVICES in the following settings:

1. A certified Adult Mental Health Day Treatment Program as defined in HFS 61.75 Wis. Adm. Code.
2. A certified Child/Adolescent Mental Health Day Treatment Program as defined in HFS 40.04 Wis. Adm. Code.
3. A certified AODA Day Treatment Program as defined in HFS 75.12(1) and (2) Wis. Adm. Code.
4. A certified Community Support Program as defined in HFS 63.03 Wisc. Adm. Code.
5. A certified Residential AODA Treatment Program as defined in HFS 75.14(1) and (2) Wis. Adm. code.

Definitions (cont.)

6. Intensive outpatient programs for the treatment of drug and alcohol disorders provided in accordance with the criteria established by the american Society of Additional Medicine.
7. Services provided by a program certified under HFS 34.03 and provided in accordance with subchapter III HFS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to their Providers for stabilization.
8. Out of state SERVICES and programs that are substantially similar to (1), (2), (3), (4), and (5) if the provider is in compliance with similar requirements of the state in which the health care provider is located.

TRANSPLANTATION means GRAFTING of tissue or organ, including parts or substances from the same body or from another body.

STANDARD PLAN SCHEDULE OF BENEFITS

The following limitations apply to all SERVICES and supplies received from PREFERRED PROVIDERS and NON-PREFERRED PROVIDERS and that are covered BENEFITS.

A. DEDUCTIBLE

Each PARTICIPANT is required to pay the DEDUCTIBLE amount shown below before BENEFITS are payable.

1. PREFERRED PROVIDERS
   $100.00 per CALENDAR YEAR per PARTICIPANT.
2. NON-PREFERRED PROVIDER
   $500.00 per CALENDAR YEAR per PARTICIPANT.

Two hundred dollars ($200.00) is the maximum aggregate DEDUCTIBLE amount required under one family coverage in a CALENDAR YEAR **in network.**

One thousand dollars ($1,000.00) is the maximum aggregate DEDUCTIBLE amount required under one family coverage in a CALENDAR YEAR **out of network.**

The PREFERRED and NON-PREFERRED PROVIDER DEDUCTIBLES are separate and cannot be combined.

If any portion of either the in network or out-of-network DEDUCTIBLE is incurred during the last three months of a CALENDAR YEAR, that portion will be applied toward the PARTICIPANT'S DEDUCTIBLE for the next CALENDAR YEAR.

If 2 or more PARTICIPANT'S under the same family coverage incur expenses for BENEFITS as a result of injuries received in the same accident, only one DEDUCTIBLE is required for all BENEFITS related to that accident. The DEDUCTIBLE applies to all BENEFITS, unless the CONTRACT states otherwise.

B. COINSURANCE

After a PARTICIPANT pays the DEDUCTIBLE each CALENDAR YEAR, the PARTICIPANT must also pay the following:

COINSURANCE amounts subject to the limitation described in Section C below:

1. For BENEFITS performed by a PREFERRED PROVIDER:
   None

2. For BENEFITS performed by a NON-PREFERRED PROVIDER:

After the PARTICIPANT satisfies the DEDUCTIBLE each CALENDAR YEAR, they pay 20% COINSURANCE for BENEFITS. The most COINSURANCE the PARTICIPANT pays for BENEFITS performed by a NON-PREFERRED PROVIDER in a CALENDAR YEAR is $1,500.00 per PARTICIPANT and $3,000.00 per family coverage. Thereafter, we pay 100% of CHARGES for BENEFITS incurred in that CALENDAR YEAR , up to the maximum benefit. The COINSURANCE applies to all BENEFITS, unless the CONTRACT states otherwise.

C. ANNUAL OUT-OF-POCKET LIMIT

The annual OUT-OF-POCKET limit is $2,000.00 per PARTICIPANT for NON-PREFERRED PROVIDERS, not to exceed $4,000.00 per family. This total is made up of the DEDUCTIBLE and COINSURANCE amounts a PARTICIPANT pays for covered expenses in one CALENDAR YEAR. No benefits are payable for CHARGES unused to satisfy a PARTICIPANT'S annual DEDUCTIBLE amount and COINSURANCE amounts.

After the annual OUT-OF-POCKET limit is satisfied, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in this Section, incurred by a PARTICIPANT during the remainder of the CALENDAR YEAR, subject to the PARTICIPANT lifetime maximum benefit limit.

D. LIFETIME MAXIMUM BENEFITS

$2,000,000.00 per PARTICIPANT.

STANDARD PLAN BENEFITS

A. INPATIENT HOSPITAL SERVICES

HOSPITAL INPATIENT SERVICES are subject to the "ADVANTAGE PROGRAM" guidelines. See the "ADVANTAGE PROGRAM" section for further information.

Except as excluded in the CONTRACT, BENEFITS are payable for the following HOSPITAL SERVICES for each PARTICIPANT admitted to a HOSPITAL, SPECIALTY HOSPITAL or EXTENDED CARE FACILITY that is a PREFERRED PROVIDER or NON-PREFERRED PROVIDER on or after his/her EFFECTIVE DATE if SERVICES are consistent with and MEDICALLY NECESSARY for admission, diagnosis and treatment, as determined by BCBSUW.

1. Medical Conditions
   a. CONFINEMENT in a GENERAL HOSPITAL or SPECIALTY HOSPITAL.

      This applies to those PARTICIPANTS admitted as INPATIENT in a GENERAL HOSPITAL or SPECIALTY HOSPITAL for treatment of an ILLNESS, other than Alcoholism, Drug Abuse and NERVOUS and MENTAL DISORDERS, and INJURY.

      BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT. See "Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders" for those applicable BENEFITS.

      1) CHARGES for room and board, which include nursing SERVICES, for occupancy of semi-private or lesser accommodations. Covered CHARGES shall include tube feedings in lieu of tray service when MEDICALLY NECESSARY, but not both.
      2) CHARGES for miscellaneous HOSPITAL expenses.

   b. CONFINEMENT in an EXTENDED CARE FACILITY.

BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL or SPECIALTY HOSPITAL day per period of disability, available only if PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL or SPECIALTY HOSPITAL to an EXTENDED CARE FACILITY.

c. Benefit Levels

The benefit levels that apply on the HOSPITAL admission date apply to the CHARGES for the covered expenses incurred for the entire CONFINEMENT regardless of changes in benefit levels during the CONFINEMENT. If the PARTICIPANT is transferred to another HOSPITAL or other facility for continued treatment of the same or related ILLNESS or INJURY, it's still just one CONFINEMENT.

B. Outpatient Hospital Services

OUTPATIENT SERVICES are covered. This includes use of operating, delivery, and treatment rooms and equipment; dressings, supplies, casts and splints.

OUTPATIENT SERVICES include:

1. First aid INJURY care. Includes subsequent care for the same INJURY or surgical care.
2. EMERGENCY MEDICAL CARE. The ILLNESS' final diagnosis or degree of severity must confirm that immediate medical care was required. (See "Emergency Services" under the section titled "PROFESSIONAL SERVICES" for examples.)
3. Chemotherapy, surgical procedures and HOSPITAL SERVICES in connection with medically recognized procedures performed as a substitute for surgery. Includes subsequent care for the same INJURY or surgical care.
4. Laboratory tests and X-ray examinations including mammograms. The benefit for mammograms is in compliance with the State of Wisconsin mandate.
5. X-ray and radiation.

Standard Plan Benefits (cont.)

C. Professional Services

Except as excluded in the CONTRACT, BENEFITS are payable for CHARGES by a PREFERRED PROVIDER or NON-PREFERRED PROVIDER for the following PROFESSIONAL SERVICES and OTHER SERVICES for each PARTICIPANT on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the diagnosis and treatment of the PARTICIPANT, as determined by BCBSUW.

1. SURGICAL SERVICES

   SURGICAL SERVICES consisting of recognized operative and cutting procedures, including PREOPERATIVE CARE, POSTOPERATIVE CARE and SERVICES of assistants and consultants. Services must be MEDICALLY NECESSARY for the treatment of an ILLNESS and/or any procedures recognized in the treatment of an INJURY, wherever performed. This includes; sprains and strains in non-hospitalized cases (limited to payment for three treatments for any one INJURY), Chemotherapy, legal abortions and any medically recognized procedures performed as a substitute for surgery.

2. MATERNITY SERVICES

   MATERNITY SERVICES, including miscarriages, MEDICALLY NECESSARY cesarean sections and sterilization procedures.

3. MEDICAL SERVICES

   MEDICAL SERVICES provided to an INPATIENT and to a PARTICIPANT receiving HOME CARE SERVICES.

4. Anesthesia SERVICES

   Anesthesia SERVICES in connection with SERVICES that are a benefit under the CONTRACT.

5. Radiation Therapy Services

   Radiation therapy SERVICES utilizing generally accepted radiological therapy such as x-ray, radium or radioactive isotopes.

6. Diagnostic Services

   Diagnostic SERVICES for x-ray examinations including mammograms and laboratory tests. The benefit for mammograms is in compliance with the State of Wisconsin mandate.

Standard Plan Benefits (cont.)

7. ORAL SURGERY Services and associated x-rays

   The extraction of teeth other than by surgery, dental implants, root canal procedures, filling, capping, recapping or other routine repair or maintenance of teeth are excluded.

8. EMERGENCY SERVICES

   a. First aid INJURY emergency SERVICES.

   b. EMERGENCY MEDICAL CARE. The ILLNESS' symptoms must be of sufficient severity to lead a reasonably prudent layperson to conclude that immediate medical care was required.

      Examples of conditions which would constitute medical emergencies:

      - Acute allergic reactions;
      - Acute asthmatic attacks;
      - Convulsions;
      - Epileptic seizures;
      - Acute Hemorrhage;
      - Acute appendicitis;
      - Acute or suspected poisoning;
      - Coma;
      - Heart attack;
      - Attempted suicide;
      - Suffocation;
      - Stroke;
      - Drug overdoses;
      - Loss of consciousness;
      - Any condition for which the patient is admitted to the HOSPITAL as an INPATIENT.

D. Coordinated Home Care Services

1. Definitions.

   The following definitions apply to this subsection only:

HOME CARE: means the MEDICALLY NECESSARY care and treatment of a PARTICIPANT in lieu of and as an extension of care in a HOSPITAL under the active supervision of the attending PHYSICIAN, in accordance with an organized coordinated HOME CARE program agreed to and participated in by the PARTICIPANT, the Visiting Nurse Association or a similar not-for-profit or governmental community nursing service, and the HOSPITAL to which the PARTICIPANT is confined.

PROVIDER: means a HOSPITAL, PHYSICIAN or other provider licensed where required and performing within the scope of their license.

2. Eligibility.

   A PARTICIPANT is eligible for HOME CARE SERVICES **only** if the following conditions are met:

   a. There is evidence, as determined by BCBSUW, that the PARTICIPANT'S HOSPITAL CONFINEMENT can be substantially reduced by participation in an existing coordinated HOME CARE program serving the area of residence of the PARTICIPANT, provided that the PARTICIPANT does not require psychiatric care, CUSTODIAL CARE or private duty nursing.

   b. The PARTICIPANT'S attending PHYSICIAN certifies that skilled nursing is necessary and sufficient for continued care or treatment of the same ILLNESS or INJURY for which the PARTICIPANT was hospitalized.

   c. The PARTICIPANT consents in writing to be discharged from the HOSPITAL and to accept HOME CARE SERVICES.

   d. The home environment, family relationships and other resources appear adequate to meet the PARTICIPANT'S needs with the help of HOME CARE.

   e. The PARTICIPANT'S placement on the HOME CARE program is arranged by the HOME CARE coordinator prior to the PARTICIPANT'S discharge from the HOSPITAL.

   f. Affirmative proof of CHARGES for HOME CARE SERVICES is furnished to BCBSUW by the coordinating agency.

3. BENEFITS.

Provided that a PARTICIPANT remains home confined, BENEFITS are payable for CHARGES for the following HOME CARE SERVICES provided to the PARTICIPANT:

a. Home nursing care provided by or under the supervision of a registered nurse of the Visiting Nurse Association or Public Health Nursing Service.

b. HOSPITAL SERVICES, other than room and board and nursing SERVICES, furnished or provided by the HOSPITAL, under the supervision of the HOSPITAL, either at the OUTPATIENT department of the HOSPITAL or in the PARTICIPANT'S home.

c. Transportation of the patient to or from the HOSPITAL or PHYSICIAN'S office, as arranged by the HOME CARE coordinator.

4. Limitation.

The number of HOME CARE days available is the same as the number of in-hospital days remaining on the day of HOSPITAL discharge. HOME CARE days do not reduce the number of in-HOSPITAL days available.

5. Exclusions.

No BENEFITS are provided for:

a. any SERVICES not specifically listed above;

b. SERVICES or supplies not included in the HOME CARE plan established for the patient; or

c. CUSTODIAL CARE and psychiatric care.

Any BENEFITS available under the mandated HOME CARE benefit will be reduced by any BENEFITS paid under the coordinated HOME CARE, wherever available.

E. Mandated Home Care Services

Benefits

Standard Plan Benefits (cont.)

This subsection applies only if CHARGES for HOME CARE SERVICES are not covered elsewhere under the CONTRACT. A Department licensed or MEDICARE certified home health agency or certified rehabilitation agency must provide or coordinate the SERVICES. A PARTICIPANT should make sure the agency meets this requirement before SERVICES are provided. BENEFITS are payable for CHARGES for the following SERVICES when MEDICALLY NECESSARY for treatment:

a. Part-time or intermittent home nursing care by or under supervision of a registered nurse;

b. Part-time or intermittent home health aide SERVICES when MEDICALLY NECESSARY as part of the HOME CARE plan. The SERVICES must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;

c. Physical, respiratory, occupational or speech therapy;

d. MEDICAL SUPPLIES; prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory service by or on behalf of a HOSPITAL. If needed under the HOME CARE plan, these items are covered to the extent they would be if the PARTICIPANT had been hospitalized;

e. Nutrition counseling provided or supervised by a registered dietician;

f. Evaluation of the need for a HOME CARE plan by a registered nurse, physician extender or medical social worker. The PARTICIPANT'S attending PHYSICIAN must request or approve this evaluation.

1. Limitations.

The following limits apply to HOME CARE SERVICES:

a. HOME CARE isn't covered unless the PARTICIPANT'S attending PHYSICIAN certifies that:

- hospitalization or CONFINEMENT in a LICENSED SKILLED NURSING FACILITY would be needed if the PARTICIPANT didn't have HOME CARE; and

- members of the PARTICIPANT'S IMMEDIATE FAMILY or others living with the PARTICIPANT couldn't give the PARTICIPANT the care and treatment he/she needs without undue hardship;

b. If the PARTICIPANT was hospitalized just before HOME CARE started, the PARTICIPANT'S PHYSICIAN during his/her HOSPITAL stay must also approve the HOME CARE plan;

c. BENEFITS are payable for CHARGES for up to 40 HOME CARE visits in any 12 month period per PARTICIPANT. Each visit by a person providing SERVICES under a HOME CARE plan, evaluating the PARTICIPANT'S need or developing a plan counts as one visit.

   Each period of up to four straight hours in a 24-hour period of home health aide service counts as one HOME CARE visit.

d. If HOME CARE is covered under two or more health insurance contracts or plans, coverage is payable under only one of them. The same is true if the PARTICIPANT has HOME CARE coverage under the CONTRACT and another source;

e. The maximum weekly benefit for this coverage won't be more than the weekly CHARGES for SKILLED NURSING CARE in a LICENSED SKILLED NURSING FACILITY, as determined by BCBSUW.

F. Home Attendance Care

BENEFITS are payable for CHARGES for home attendance and care recommended by the attending PHYSICIAN and provided by other than a registered or licensed practical nurse or a member of the PARTICIPANT's family. The maximum benefit limit is 150 days at $10.00 per day during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the CONTRACT.

Standard Plan Benefits (cont.)

G. Hospice Services

Except as otherwise excluded in the CONTRACT, BENEFITS are payable for CHARGES for the SERVICES described in this section according to the terms and conditions of the CONTRACT for each PARTICIPANT receiving such SERVICES on or after his/her EFFECTIVE DATE; provided those SERVICES are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by BCBSUW, and are not paid or payable elsewhere under the CONTRACT.

1. BENEFITS are payable for CHARGES for the following HOSPICE CARE SERVICES:
   a. Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
   b. Part-time or intermittent home health SERVICES when MEDICALLY NECESSARY. Such SERVICES must be under the supervision of a registered nurse or medical social worker and consist solely of care for the PARTICIPANT;
   c. Physical, respiratory, occupational or speech therapy;
   d. MEDICAL SUPPLIES; prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN required to be administered by a professional provider; laboratory SERVICES by or on behalf of a HOSPITAL. These services are covered to the extent CHARGES would be payable for these items under the CONTRACT if the PARTICIPANT had been hospitalized;
   e. Nutrition counseling provided or supervised by a registered nurse, physician extender or medical social worker, when approved or requested by the attending PHYSICIAN; and
   f. Room and board CHARGES at a BCBSUW approved or MEDICARE certified HOSPICE CARE facility.

   CHARGES for weekly HOSPICE CARE SERVICES are payable up to the weekly CHARGES for SKILLED NURSING CARE provided in an EXTENDED CARE FACILITY, as determined by BCBSUW.
2. LIMITATIONS FOR HOSPICE CARE SERVICES
   a. HOSPICE CARE is **not covered unless** the PARTICIPANT'S attending PHYSICIAN certifies that:

1) hospitalization or CONFINEMENT would otherwise be required;
2) necessary care and treatment are not available from members of a PARTICIPANT'S IMMEDIATE FAMILY, or others living with the PARTICIPANT; and
3) the PARTICIPANT is terminally ill with a life expectancy of six months or less.

b. CHARGES are payable for up to a total lifetime maximum of 30 days of CONFINEMENT in MEDICARE certified or BCBSUW approved HOSPICE CARE facility. CHARGES are payable for HOSPICE CARE SERVICES provided in a PARTICIPANT'S home up to 80 HOSPICE CARE visits within any six month period.

Up to four consecutive hours of HOSPICE CARE SERVICES in a PARTICIPANT'S home is considered as one HOSPICE CARE visit.

H. Treatment of Alcoholism, Drug Abuse and NERVOUS or MENTAL DISORDERS

Total BENEFITS payable for all Treatment of Alcoholism, Drug Abuse and NERVOUS or MENTAL DISORDERS, shall not exceed the annual maximum amount of S7,000.00 per PARTICIPANT per CALENDAR YEAR.

Note: Annual dollar maximum for mental health only SERVICES are suspended.

Annual dollar maximums remain in force for treatment of alcohol and drug abuse. Any BENEFITS paid during the year for mental health SERVICES will be applied toward the annual benefit maximum for alcohol and drug abuse treatment when determining whether BENEFITS for alcohol and drug abuse treatment remain available.

1. Inpatient Treatment of Nervous or Mental Disorders.

a. CONFINEMENT in a GENERAL HOSPITAL.

This applies to those PARTICIPANTS admitted as resident patients in a GENERAL HOSPITAL for treatment of NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 120 days per CONFINEMENT.

Standard Plan Benefits (cont.)

When successive CONFINEMENTS in one or more GENERAL HOSPITALS occur with less than 60 days between any discharge and the next admission, they shall constitute one period of CONFINEMENT.

1) CHARGES for room and board, which include nursing SERVICES, for occupancy of semi-private or lesser accommodations.

   If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL's average daily rate for all its two-bed rooms; and

2) CHARGES for miscellaneous HOSPITAL expenses.

b. CONFINEMENT in a SPECIALTY HOSPITAL.

This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for treatment of NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable for CHARGES for up to $50.00 a day for HOSPITAL expenses actually incurred during the first 120 days per CONFINEMENT.

When successive CONFINEMENTS in one or more GENERAL HOSPITALS occur with less than 60 days between any discharge and the next admission, they shall constitute one period of CONFINEMENT.

Total BENEFITS payable under a. and b., above will not exceed 120 days per CONFINEMENT, renewable after 60 days separation.

c. CONFINEMENT in an EXTENDED CARE FACILITY.

BENEFITS are limited to two days of CONFINEMENT for each unused HOSPITAL or SPECIALTY HOSPITAL day per period of disability, available only if a PARTICIPANT is transferred from CONFINEMENT in a HOSPITAL or SPECIALTY HOSPITAL to an EXTENDED CARE FACILITY.

2. Inpatient Treatment of Alcoholism and Drug Abuse.

a. CONFINEMENT in a GENERAL HOSPITAL.

This applies to those PARTICIPANTS admitted as resident patients in a GENERAL HOSPITAL for treatment of Alcoholism and Drug Abuse.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT.

1) CHARGES for room and board, which include nursing SERVICES, for occupancy of semi-private or less accommodations.

   If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL's average daily rate for all its two bed rooms; and

2) CHARGES for miscellaneous HOSPITAL expenses.

b. CONFINEMENT in a SPECIALTY HOSPITAL.

   This applies to those PARTICIPANTS admitted as resident patients in a SPECIALTY HOSPITAL for treatment of alcoholism and drug abuse.

   BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred for up to 30 days per CALENDAR YEAR.

   1) CHARGES for room and board, which include nursing SERVICES, for occupancy of semi-private or lesser accommodations.

   2) CHARGES for miscellaneous HOSPITAL expenses.

   3) OUTPATIENT SERVICES directly related to a HOSPITAL admission and provided as a continuing part of a drug addiction or alcoholism treatment program will be handled as follows:

      CHARGES for SERVICES provided in addition to SPECIALTY HOSPITAL INPATIENT SERVICES are limited to payment of $250.00 for any PARTICIPANT during any CALENDAR YEAR.

3. Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS Maximums

   Total BENEFITS payable for INPATIENT alcoholism, drug abuse and NERVOUS OR MENTAL DISORDERS will not exceed $6,300.00 per PARTICIPANT per CALENDAR YEAR.

4. OUTPATIENT Treatment of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS

Treatment of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to 90% of the first $2,000.00 in CHARGES during any CALENDAR YEAR.

Such treatment SERVICES must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology, a facility established and maintained according to rules promulgated under Wis. Stats. § 51.42 (7) (b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

5. TRANSITIONAL TREATMENT ARRANGEMENTS.

   Each CALENDAR YEAR, BENEFITS are payable at 90% of the first $3,000.00 of CHARGES for covered expenses incurred by a PARTICIPANT in that CALENDAR YEAR for TRANSITIONAL TREATMENT ARRANGEMENTS provided to that PARTICIPANT up to $2,700.00 in each CALENDAR YEAR.

   The criteria that BCBSUW uses to evaluate a Transitional Treatment program or service to determine whether it is covered under the CONTRACT include, but are not limited to:

   a. the program is certified by the Department of Health and Family Services;
   b. the program meets the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations;
   c. the specific diagnosis is consistent with the symptoms;
   d. the treatment is standard medical practice and appropriate for the specific diagnosis;
   e. the multi-disciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the service is provided;
   f. see the definition of "MEDICALLY NECESSARY" in the Definitions.

   BCBSUW will need the following information from the health care provider to help determine the medical necessity of such program or service:

      1) a summary of the development of the PARTICIPANT'S ILLNESS and previous treatment;

2) a well defined treatment plan listing treatment objectives, goals and duration of the care provided under the transitional treatment arrangement program;

3) a list of credentials for the staff who participated in the TRANSITIONAL TREATMENT ARRANGEMENT program or service, unless the program or service is certified by the Department of Health and Family Services.

I. Ambulance Service

a. BENEFITS are payable for CHARGES for professional licensed ambulance service when necessary to transport a PARTICIPANT to or from a HOSPITAL or SPECIALTY HOSPITAL. SERVICES include a substitute means of transportation in medical emergencies or other extraordinary circumstances where professional licensed ambulance service is unavailable and such transportation is substantiated by a PHYSICIAN as being MEDICALLY NECESSARY.

J. Treatment of Temporomandibular Disorders

Covers diagnostic procedures and prior authorized Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders, if all of the following apply:

1) A CONGENITAL, developmental or acquired deformity, disease or injury caused the condition.

2) The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care provider rendering the service.

3) The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

This includes coverage of non-surgical treatment, including intraoral splint therapy, but does not include coverage for cosmetic or elective orthodontic, periodontic or general dental care. Benefits for diagnostic procedures and non-surgical treatment will be payable up to $1,250.00 per CONTRACT year.

TRANSPLANTATIONS, IMPLANTATIONS AND GRAFTING

Except as otherwise specifically excluded in the CONTRACT, BENEFITS for CHARGES are payable for each PARTICIPANT receiving such SERVICES in connection with the BENEFITS described in this section on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by BCBSUW.

A. BENEFITS

1. TRANSPLANTATIONS.

   The following TRANSPLANTATIONS are covered by the CONTRACT:

   a. Autologous (self to self) and allogenic (donor to self) BONE MARROW TRANSPLANTATIONS and peripheral blood stem cell rescue and/or TRANSPLANTATIONS used only in the treatment of:

      - Mydlodysplastic syndrome
      - Homozygous Beta-Thalassemia
      - Mucopolysaccharidoses (e. g. Gaucher's disease, Metachromatic Leukodystrophy, Adrenoleukodystrophy)
      - Neuroblastoma
      - Multiple Myeloma, Stage II or Stage III
      - Germ Cell Tumors (e. g. testicular, mediastinal, retroperitoneal or ovarian) refractory to standard dose chemotherapy with FDA approved platinum compound
      - Aplastic anemia;
      - Acute leukemia;
      - Severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies;
      - Wiskott - Aldrich syndrome;
      - Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease);
      - Hodgkins' and non-Hodgkins' lymphoma;
      - Combined immunodeficiency;

Transplantation, Implantations and Grafting (cont.)

- Chronic myelogenous leukemia;
- Pediatric tumors based upon individual consideration.

b. Parathyroid TRANSPLANTATION.

c. Musculoskeletal TRANSPLANTATIONS intended to improve the function and appearance of any body area which has been altered by disease, trauma, CONGENITAL anomalies or previous therapeutic processes.

d. Corneal TRANSPLANTATION (keratoplasty) limited to:

- Corneal opacity;
- Keratoconus or any abnormality resulting in an irregular refractive surface not correctable with a contact lens or in a PARTICIPANT who cannot wear a contact lens;
- Corneal ulcer;
- Repair of severe lacerations.

e. Kidney.

2. IMPLANTATIONS.

The following IMPLANTATIONS are covered by the CONTRACT:

a. Heart valve IMPLANTATION;

b. Pseudophakia (intracular lens) IMPLANTATION;

c. Penile prosthesis IMPLANTATION;

d. Urethral sphincter IMPLANTATION;

e. Artificial breast IMPLANTATION.

3. GRAFTINGS.

The following GRAFTINGS are covered by the CONTRACT:

a. Bone (non-cosmetic);

b. Skin (non-cosmetic);

c. Artery;

d. Arteriovenous shunt;

e. Blood vessel limited to blood vessel repair;

f. Cartilage (non-cosmetic);

g. Conjunctiva;

h. Fascia;

i. Lid margin (non-cosmetic);

j. Mucosa;
k. Bronchoplasty;
l. Coronary bypass;
m. Mucus membrane;
n. Muscle;
o. Nerve;
p. Pterygium;
q. Rectal (Thiersch operation);
r. Sclera;
s. Tendon;
t. Vein (bypass).

B. EXCLUSIONS

BENEFITS are not payable for any form of or SERVICES related to TRANSPLANTATION, IMPLANTATION or GRAFTING other than those specifically listed in this section.

Examples of procedures that are **not payable:**

a. Heart TRANSPLANTATION;
b. Intestine TRANSPLANTATION;
c. Islet tissue (island of Langerhans-pancreas) TRANSPLANTATION;
d. Liver TRANSPLANTATION;
e. Lung TRANSPLANTATION;
f. Pancreas TRANSPLANTATION;
g. Bladder stimulator (pacemaker) IMPLANTATION;
h. Implantable or portable artificial kidney or other similar device; or
i. Dental implants.

OTHER BENEFITS PAYABLE

Except as excluded in the CONTRACT, BENEFITS received from a PREFERRED PROVIDER or NON-PREFERRED PROVIDER are payable for CHARGES for treatment, SERVICES and supplies listed in this Section.

A. OTHER BENEFITS PAYABLE

After satisfaction of the DEDUCTIBLE, BENEFITS are payable for CHARGES for the following major medical SERVICES if the SERVICES are received after the PARTICIPANT'S EFFECTIVE DATE under the CONTRACT and are MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by BCBSUW.

a. PROFESSIONAL SERVICES, including psychiatric therapy SERVICES to INPATIENTS.

b. Physical examinations performed and billed by a PHYSICIAN. Physical examinations requested by a third party are not covered under the CONTRACT.

c. Physical, speech and occupational therapy when necessitated by an ILLNESS or INJURY by a registered physical, speech or occupational therapist other than one who ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S family.

d. Special duty nursing by a registered or licensed practical nurse other than one who ordinarily resides in the PARTICIPANT'S home or who is a member of the PARTICIPANT'S family.

e. Total extraction or total replacement of natural teeth by a PHYSICIAN when necessitated by an INJURY. The INJURY and treatment must occur while the PARTICIPANT is continuously covered under the CONTRACT or a preceding CONTRACT provided through the BOARD. A dental repair method, other than extraction and replacement, may be considered if approved by BCBSUW before the service is performed. This includes dentures but does not include dental implants.

Other Benefits Payable (cont.)

f. MEDICAL SUPPLIES prescribed by a PHYSICIAN. BENEFITS are payable only if BCBSUW approves the supply as being appropriate for a PARTICIPANT'S medical condition. Such MEDICAL SUPPLIES include, but are not limited to:

1) Blood or blood plasma.

2) Initial acquisition of artificial limbs or eyes including replacements due to significant physiological changes, such as physical maturation, when MEDICALLY NECESSARY, and refitting of any existing prosthesis is not possible.

3) Casts, splints, trusses, crutches, orthopedic braces and appliances, custom made orthotics, therapeutic contact lenses and cataract lenses following cataract surgery.

4) Rental of or, at the option of BCBSUW, purchase of DURABLE MEDICAL EQUIPMENT.

When the equipment is purchased, BENEFITS are payable for subsequent repairs necessary to restore the equipment to a serviceable condition, such as, but not limited to: wheelchairs, hospital-type beds and artificial respiration equipment. Routine periodic maintenance and replacement of batteries are not covered.

5) Oxygen and rental of equipment for the administration of oxygen.

6) Rental of radium and radioactive isotopes.

g. OUTPATIENT cardiac rehabilitation SERVICES. Services must be approved by BCBSUW and provided in an OUTPATIENT department of a HOSPITAL, in a medical center or clinic program. This benefit applies only to PARTICIPANTS with a recent history of:

- a heart attack (myocardial infarction);
- coronary bypass surgery;
- onset of angina pectoris;
- heart valve surgery;
- onset of decubital angina;
- onset of unstable angina; or

- percutaneous transluminal angioplasty.

BENEFITS are payable only for eligible PARTICIPANTS who begin an exercise program immediately following their HOSPITAL CONFINEMENT for one of the conditions shown above. BENEFITS are limited to CHARGES for three sessions per week for 26 weeks beginning with the first session in the OUTPATIENT exercise program. Immediately is defined as commencing within 3 months following the date of service of the procedure. This time frame may be extended if individual circumstances warrant and are documented as MEDICALLY NECESSARY.

BENEFITS are not payable for behavioral or vocational counseling. A new BENEFIT PERIOD is available following a subsequent period of hospitalization for any of the conditions listed in this paragraph. No other BENEFITS for OUTPATIENT cardiac rehabilitation SERVICES are available under the CONTRACT.

h. CHARGES for BIOLOGICALS, and prescription drugs required to be administered during an office visit with a PHYSICIAN for treatment of an ILLNESS or INJURY.

ADVANTAGE PROGRAM

This coverage has a managed care program. Please read this section very carefully. If you do not follow the procedures described below, your BENEFITS for MEDICALLY NECESSARY covered SERVICES will be reduced. Remember that BCBSUW does not pay BENEFITS for SERVICES which are not MEDICALLY NECESSARY, regardless of whether you followed procedures. This section does not apply to you if MEDICARE is your primary payor.

A. ADMISSION AUTHORIZATION

1. Non-Emergency Admission

   At least 48 hours before you are admitted to the HOSPITAL for non-emergency care, you must call us. This starts our process of HOSPITAL admission review. We will authorize your HOSPITAL admission if it is MEDICALLY NECESSARY, or deny it if it is not MEDICALLY NECESSARY. If you do not obtain pre-authorization at least 48 hours before a MEDICALLY NECESSARY non-emergency admission, your usual, customary and reasonable CHARGES for covered SERVICES will be reduced by $100.00 per admission. BENEFITS for reduced CHARGES are calculated according to CONTRACT provisions. You must pay the penalty plus any DEDUCTIBLE and COINSURANCE.

2. Emergency Admission

   In an emergency, you or a member of your family must call us within 48 hours of your HOSPITAL admission. We will authorize your continued stay if it is MEDICALLY NECESSARY, or deny it if it is not MEDICALLY NECESSARY. If you do not obtain authorization within 48 hours of a MEDICALLY NECESSARY emergency admission, your usual, customary and reasonable CHARGES for covered SERVICES will be reduced by $100.00 per admission. BENEFITS for reduced CHARGES are calculated according to CONTRACT provisions. You must pay the penalty plus any DEDUCTIBLE and COINSURANCE.

   If it is impossible to call us within 48 hours of admission, but you or a member of your family call as soon as possible, the penalty for failure to call will not apply.

B. CONTINUED STAY AUTHORIZATION

We will contact the HOSPITAL on your expected discharge date. If you are to stay in the HOSPITAL longer than originally authorized, we will request the medical reasons from your doctor or HOSPITAL. After reviewing these reasons, if we determine that continued hospitalization isn't MEDICALLY NECESSARY, you, the HOSPITAL and doctor will be notified. You will not receive BENEFITS for room and board CHARGES for unauthorized days.

C. SECOND SURGICAL OPINION

If your PHYSICIAN recommends elective surgery, you may obtain a second or third opinion from another PHYSICIAN. We pay usual, customary, and reasonable CHARGES for a consultation and necessary diagnostic SERVICES.

An elective Surgery is any non-emergency surgery which, in the judgment of your PHYSICIAN, can be scheduled at your convenience without:

1. Jeopardizing your life; or
2. Causing serious impairment to your bodily functions.

If you elect to have the proposed surgery, we pay BENEFITS for the Surgery according to CONTRACT provisions regardless of the opinion given.

D. TELEPHONE NUMBERS

The Managed Care telephone number is:

- 1-800-472-8909

Remember, it is your responsibility to call us, or to have someone call on your behalf.

MEDICARE PLUS $100,000

Medicare Plus $100,000 is designed to supplement, not duplicate, BENEFITS available under the federal MEDICARE program. It is designed for ANNUITANTS and is not available to active EMPLOYEES, their spouses or DEPENDENTS.

See the booklet "State Medicare Plus $100,000" for a description of BENEFITS and other provisions of the plan. Additional information may be obtained by referring to "Your MEDICARE Handbook" published by the Social Security Administration.

1. Unless you are an active (non-retired) state EMPLOYEE, all family members must enroll in MEDICARE (both Part A - HOSPITAL and Part B - Medical) when first eligible. Otherwise, State Group Health coverage is subject to cancellation without the right of reinstatement. This requirement is deferred for active EMPLOYEES (and their DEPENDENTS) until the SUBSCRIBER'S termination of state employment.
2. Those family members not eligible for MEDICARE will continue their Standard or SMP coverage.
3. Medicare Plus will provide uninterrupted coverage from Standard coverage or SMP.
4. The maximum benefit of this coverage for any one ILLNESS or INJURY is $100,000.00, which is in addition to BENEFITS paid by MEDICARE.
5. Medicare Plus provides reimbursement for all DEDUCTIBLES under MEDICARE Part A (Hospitalization) and MEDICARE Part B (Medical) if you have incurred at least that DEDUCTIBLE amount in covered expenses during the CALENDAR YEAR.
6. Medicare Plus provides payment for prescribed or recommended SERVICES or supplies which may not be covered or fully covered by MEDICARE.

GENERAL EXCLUSIONS

Except as otherwise specifically provided, the CONTRACT provides no BENEFITS for:

1. CUSTODIAL CARE or rest cures, wherever furnished, care in custodial or similar institutions, a health resort, spa or sanitarium.
2. Physical examinations or health checkups for informational purposes requested by third parties. Examples: physical exams required by schools, summer camp, employment, marriage, insurance, sports, etc.
3. Services of a blood donor.
4. Treatment, SERVICES and supplies for cosmetic or beautifying purposes, except to correct CONGENITAL bodily disorders or conditions or when medically necessitated by an ILLNESS or accidental INJURY.
5. Eye glasses, contact lenses, hearing aids or examinations for their prescription.
6. Treatment of corns and calluses of the feet, toenails (except for complete removal), overgrowth of the skin of the feet, unless prescribed by a PHYSICIAN who is treating the PARTICIPANT for a metabolic or peripheral disease.
7. Services of a dentist, including all orthodontic SERVICES, or SERVICES provided in the examination, repair or replacement of teeth, or in the extraction of teeth, dental implants, or treatment for Temporomandibular Joint Disease (TMJ) other than recognized radical ORAL SURGERY, except as expressly provided in the CONTRACT. An accident caused by chewing is not considered an INJURY.
8. Treatment, SERVICES and supplies:
    a. that would be furnished to a PARTICIPANT without CHARGE;
    b. which a PARTICIPANT would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government; or

General Exclusions (cont.)

c. which a PARTICIPANT would be entitled, or would be entitled if enrolled, to have furnished or paid for under any voluntary medical benefit or insurance plan established by any government; if the CONTRACT was not in effect.

9. Treatment, SERVICES and supplies for any INJURY or ILLNESS eligible for coverage, or for which a PARTICIPANT receives, or which is the subject of, any award or settlement under a Worker's Compensation Act or any EMPLOYER liability law.
10. Treatment, SERVICES and supplies for any INJURY or ILLNESS as the result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or any State of the United States, or its Allies, or while serving in the Armed Forces of any country.
11. Treatment, SERVICES and supplies furnished by the U.S. Veterans Administration, except for such treatment, SERVICES and supplies for which under the CONTRACT, the CONTRACT is the primary payor and the U.S. Veterans Administration is the secondary payor under applicable federal law.
12. Treatment, SERVICES and supplies available from OTHER COVERAGE. Then, BENEFITS will be limited to the CHARGES for treatment, SERVICES and supplies, less payments available from OTHER COVERAGE. Together, the total BENEFITS payable may not exceed the incurred CHARGES. In computing allowances available, the primary carrier according to Wis. Adm. Code § Ins. 3.40 will provide the full BENEFITS payable under its CONTRACT, with the other carrier processing the remainder of those CHARGES. However, when MEDICARE is primary, payment of BENEFITS is limited to the amount computed without coordination of BENEFITS, less the MEDICARE payments. MEDICARE allowed amount on assigned claims is considered the CHARGE; on unassigned claims, the CHARGE is the MEDICARE limiting CHARGE amount. If the PARTICIPANT is not actually enrolled in the voluntary medical insurance portion of MEDICARE when it is first available, the member’s BENEFITS are limited to the extent they are entitled, or would be entitled if enrolled for MEDICARE BENEFITS.

General Exclusions (cont.)

13. Major medical BENEFITS for treatment, SERVICES and supplies that are provided under the STANDARD PLAN ~~basic~~ coverage either in their entirety or partially because of allowance limitations, COINSURANCE or DEDUCTIBLES.
14. Any BENEFITS under sections "Hospital Services", "PROFESSIONAL SERVICES and OTHER SERVICES", "Major Medical", "Waiting Periods", "Exclusions" and "Preauthorization" if the PARTICIPANT is eligible to enroll in MEDICARE. This exclusion is not applicable until the SUBSCRIBER'S termination of employment with the State of Wisconsin.
15. PROFESSIONAL SERVICES not provided by a PHYSICIAN.
16. Treatment, SERVICES and supplies which are not MEDICALLY NECESSARY or which aren't appropriate for the treatment of an ILLNESS or INJURY, as determined by BCBSUW.
17. Reversal of sterilization.
18. Treatment, SERVICES and supplies which are EXPERIMENTAL or INVESTIGATIVE in nature, except for prescription drugs and BIOLOGICALS prescribed by a PHYSICIAN and required to be administered by a professional provider, described in Wis. Stats. § 632.895 (9) for treatment of HIV.
19. Treatment, SERVICES and supplies for, or leading to, sex transformation surgery and sex hormones related to such treatment.
20. Artificial insemination or fertilization methods including, but not limited to, in vivo fertilization, in vitro fertilization, embryo transfer, gamete intra-fallopian transfer (GIFT) and similar procedures, and related HOSPITAL, professional and diagnostic SERVICES and medications that are incidental to such insemination or fertilization methods.
21. Treatment, SERVICES and supplies provided by a midwife.
22. Food received on an OUTPATIENT basis or food supplements.
23. Housekeeping, shopping or meal preparation SERVICES.
24. Treatment, SERVICES and supplies in connection with obesity, weight reduction or dietetic control, except for morbid obesity and disease etiology.

General Exclusions (cont.)

25. Retin-A, Minoxidil, Rogaine or their medical equivalent in the topical application form, unless MEDICALLY NECESSARY.
26. Treatment, SERVICES and supplies used in educational or vocational training.
27. Treatment, SERVICES and supplies in connection with any ILLNESS or INJURY caused by a PARTICIPANT'S: (a) engaging in an illegal occupation; or (b) commission of, or an attempt to commit, a felony.
28. Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.
29. Treatment, SERVICES and supplies for which the PARTICIPANT has no obligation to pay.
30. Treatment, SERVICES and supplies rendered by a member of a PARTICIPANT'S family or a person who resides in the PARTICIPANT'S home.
31. Routine periodic maintenance of covered DURABLE MEDICAL EQUIPMENT, such as, replacement of batteries.
32. Treatment, SERVICES, and supplies for the purpose of smoking cessation.
33. Treatment, SERVICES and supplies determined to be MAINTENANCE THERAPY by BCBSUW.
34. Over-the-counter drugs.
35. Prescription drugs and BIOLOGICALS prescribed in writing by a PHYSICIAN for treatment of an ILLNESS or INJURY and dispensed by a licensed pharmacist. For purposes of this exclusion, “prescription drug” means drugs that are dispensed by a written prescription from a PHYSICIAN, under Federal law, approved for human use by the Food and Drug Administration and dispensed by a pharmacist.
36. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the Plan.
37. Charges for injectable medications obtained by a PARTICIPANT from a pharmacy for subsequent administration by a healthcare professional.
38. Services to the extent the PARTICIPANT is eligible for Medicare benefits, regardless of whether or not the PARTICIPANT is actually enrolled in Medicare. This exclusion only applies if Medicare is the primary payor.

GENERAL CONDITIONS

A. General Conditions

BENEFITS are available in accordance with the terms and conditions of the CONTRACT, including:

1. No provision of the CONTRACT shall interfere with the professional relationship between a PARTICIPANT and PHYSICIAN.
2. If a PARTICIPANT remains in an institution after being advised by the attending PHYSICIAN that further CONFINEMENT is medically unnecessary, the SUBSCRIBER will be solely responsible to the institution for all expenses incurred after being so advised. BCBSUW or the BOARD may at any time request the attending PHYSICIAN to certify that further CONFINEMENT is MEDICALLY NECESSARY.
3. Each PARTICIPANT is free to select and/or discharge a PHYSICIAN. A PHYSICIAN is free to provide service or not, in accordance with the custom in the private practice of medicine. Nothing in the CONTRACT obligates BCBSUW or the BOARD to provide a PHYSICIAN to treat any PARTICIPANT.
4. Each PARTICIPANT agrees to conform to the rules and regulations of the institution in which he/she is an INPATIENT, including those rules governing admissions and types and scope of SERVICES furnished by the institution.
5. As a condition of entitlement to receive BENEFITS, each PARTICIPANT authorizes any person or institution to furnish to BCBSUW all medical and surgical reports and other information as BCBSUW may request.
6. BCBSUW and the BOARD each have the right and opportunity to have a PARTICIPANT examined by PHYSICIANS of their choice when and as often as they may reasonably require.
7. The SUBSCRIBER'S identification card must be presented, or the fact of the SUBSCRIBER'S participation under the CONTRACT be made known, to the provider when the PARTICIPANT requests care or SERVICES.

General Conditions (cont.)

8. If a PARTICIPANT fails to comply with 7. above, then written notice of the commencement of treatment or CONFINEMENT must be given to BCBSUW within 30 days after the commencement of treatment or CONFINEMENT. Failure to give that notice will not invalidate or reduce any claim if it is shown that notice was given as soon as reasonably possible. However, no BENEFITS will be paid for CHARGES incurred in any CALENDAR YEAR unless a claim for those CHARGES is received by BCBSUW within 24 months from the date the service was rendered.
9. Each PARTICIPANT agrees to reimburse BCBSUW or the BOARD for all payments made for BENEFITS to which the PARTICIPANT was not entitled. Reimbursement must be made immediately upon notification to the SUBSCRIBER by BCBSUW or the BOARD. At the option of BCBSUW or the BOARD, BENEFITS for future CHARGES may be reduced by BCBSUW as a set-off toward reimbursement. Acceptance of premiums or paying BENEFITS for CHARGES will not constitute a waiver of the rights of BCBSUW or the BOARD to enforce these provisions in the future.
10. Each PARTICIPANT agrees to use a Major Medical Claim form when submitting for medical Benefits that are not submitted to BCBSUW by the provider. Only itemized bills, statements acknowledging actual receipt of payment, or similar receipts may serve as proof of claim. Each must be an official document from the provider. Cash register receipts that are not itemized or do not clearly identify the provider, cancelled checks, custom order forms and balance due statements alone are NOT acceptable as proof of claim.

    Each itemized bill statement or receipt must include the patient's name, patient's BCBSUW identification number, provider's name, provider's address, date(s) of service, diagnosis and diagnostic code, procedure code, and CHARGE for each date of service.

    For medical claims incurred outside of the United States, the PARTICIPANT must obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate claim processing.

General Conditions (cont.)

11. BCBSUW will, at its option, pay BENEFITS either to the provider of SERVICES or to the SUBSCRIBER.
12. Each PARTICIPANT agrees that the BOARD is subrogated to the PARTICIPANT'S rights to damages for an ILLNESS or INJURY caused by any act or omission of any third person to the extent of BENEFITS.
13. A PARTICIPANT shall not commence any action to recover any BENEFITS or enforce any rights under the CONTRACT until 60 calendar days have elapsed since written notice of claim was given by the PARTICIPANT to BCBSUW, nor will any action be brought more than three years after the SERVICES have been provided.
14. Any provisions of the CONTRACT which may be prohibited by law are void, but will not impair any other provision.
15. BCBSUW may recommend that a PARTICIPANT consider receiving treatment for an ILLNESS or INJURY which differs from the current treatment if it appears that:
    a. the recommended treatment offers at least equal medical therapeutic value; and
    b. the current treatment program may be changed without jeopardizing the PARTICIPANT'S health; and
    c. the CHARGES incurred for SERVICES provided under the recommended treatment will probably be less.

    If the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree, the recommended treatment will be provided as soon as its available.

    BENEFITS payable for the CHARGES incurred for such SERVICES shall be paid according to the terms and conditions of the CONTRACT. If the recommended treatment includes SERVICES for which BENEFITS are not otherwise payable, payment of BENEFITS will be as determined by BCBSUW.
16. BCBSUW may recommend that an INPATIENT be transferred to another institution if it appears that:
    a. the other institution is able to provide the necessary medical care; and

b. the physical transfer would not jeopardize the PARTICIPANT'S health or adversely affect the current course of treatment; and

c. the CHARGES incurred at the succeeding institution will probably be less than those CHARGES at the prior institution.

If the PARTICIPANT or his/her authorized representative and the attending PHYSICIAN agree to the transfer, the transfer will take place as soon as bed space is available.

B. Waiting Periods

BENEFITS under the CONTRACT are limited as follows:

BENEFITS for the removal of tonsils and adenoids and treatment for any ILLNESS, excluding pregnancy, or INJURY which existed on or before the EFFECTIVE DATE of a PARTICIPANT'S coverage under the CONTRACT shall be available to the PARTICIPANT only after being a PARTICIPANT under this and/or the previous CONTRACT for the 180 consecutive days preceding care or treatment of such ILLNESS or INJURY. CHARGES for HOSPITAL SERVICES are not payable for any CONFINEMENT that begins during the 180 day period.

This waiting period will not apply to a PARTICIPANT enrolled during prescribed open enrollment periods established by the BOARD.

C. PreAuthorization

BENEFITS are not payable for treatment, SERVICES and supplies that are EXPERIMENTAL, INVESTIGATIVE or not MEDICALLY NECESSARY, as determined by BCBSUW. The types of procedures or SERVICES that may fall into this category, but not limited to these, are:

1. New medical or biomedical technology;
2. Methods of treatment by diet or exercise;
3. New surgical methods or techniques;
4. Acupuncture or similar methods;
5. Transplants of body organs, unless specifically covered under the CONTRACT.

A PARTICIPANT may ask BCBSUW whether or not a treatment, service or supply will be covered and how much in BENEFITS will be paid. If a treatment, service or supply is preauthorized by BCBSUW, no payment can be made unless the PARTICIPANT'S coverage is in effect at the time the treatment, service or supply is provided to the PARTICIPANT.

If a PARTICIPANT does not use this preauthorization procedure, BCBSUW may decide that the treatment, service or supply is EXPERIMENTAL, INVESTIGATIVE or not MEDICALLY NECESSARY. No payment can then be made for the treatment, service or supply or any related treatment, service or supply.

If a PARTICIPANT or his/her PHYSICIAN disagrees with BCBSUW's decision, the PARTICIPANT may appeal that decision by submitting documentation to BCBSUW from the treating PHYSICIAN to the medical value or effectiveness of the treatment, service or supply. The appeal will be reviewed by practicing PHYSICIANS and, if necessary, an appropriate committee of BCBSUW. The decision made at that time will be final.

D. Termination and Continuation

The termination and continuation provisions for the BENEFITS available under the CONTRACT are as follows:

1. A PARTICIPANT's coverage shall terminate on the earliest of the following dates:
    a. The EFFECTIVE DATE of change to another alternate health care plan through the BOARD approved enrollment process.
    b. The expiration of the period for which PREMIUMS are paid when PREMIUMS are not paid when due.
    c. The expiration of the 36 months for which the SUBSCRIBER is allowed to continue coverage, while on a leave of absence or LAYOFF as required by state and federal law.
    d. The end of the month in which a notice of cancellation of coverage is received by the EMPLOYER or by the DEPARTMENT in the case of an ANNUITANT.
    e. The definition of PARTICIPANT no longer applies (such as a DEPENDENT child's marriage, divorced spouse, etc.).

General Conditions (cont.)

f. The expiration of the 36 months for which the PARTICIPANT is allowed to continue under Paragraph 4., below, of this subsection.

g. The EFFECTIVE DATE of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any PRE-EXISTING CONDITION of PARTICIPANT who continues under Paragraph 4., below, of this subsection.

h. The earliest date Federal or State continuation provisions permit termination of coverage for any reason, except the BOARD specifically allows EMPLOYEES to maintain coverage for 36 months instead of 18.

2. No refund of any PREMIUM may be made unless the EMPLOYER, or DEPARTMENT if applicable, receives a written request from the SUBSCRIBER by the last day of the month preceding the month for which PREMIUM has been collected or deducted.

3. Except when a PARTICIPANT's coverage terminates because of cancellation or nonpayment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if confined as an INPATIENT, but only until the attending PHYSICIAN determines that CONFINEMENT is no longer MEDICALLY NECESSARY, the CONTRACT maximum is reached, the end of 12 months after the date of termination, or CONFINEMENT ceases, whichever occurs first.

4. A PARTICIPANT who ceases to meet the definition of EMPLOYEE/ANNUITANT/DEPENDENT may elect to continue group coverage for a maximum of 36 months. Application must be received by the DEPARTMENT within 60 days of the date the PARTICIPANT is notified of the right to continue or 60 days from the date coverage ceases, whichever is later. BCBSUW shall bill the continuing PARTICIPANT directly for the required premium.

General Conditions (cont.)

5. No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER's rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN subject to the waiting period for PRE-EXISTING CONDITIONS.

   Change to an alternate plan via dual-choice enrollment is available during a regular dual-choice enrollment period which begins a minimum of 12 months after the disenrollment date.

   The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.

6. In situations where a PARTICIPANT in an alternate health plan has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care physician, disenrollment efforts may be initiated by the plan or the BOARD. The SUBSCRIBER'S disenrollment is the beginning of the month following completion of the grievance process and approval of the BOARD. Coverage will be transferred to the STANDARD PLAN, with options to enroll in alternate health care plans during subsequent dual-choice enrollment periods. Re-enrollment in the alternate plans is available during a regular dual-choice enrollment period which begins a minimum of 12 months after the disenrollment date.

General Conditions (cont.)

E. How to File a Claim

1. Present your BCBSUW identification card to the PHYSICIAN, HOSPITAL or OTHER PROVIDER of care when a covered service is received. The provider may submit the claim directly to BCBSUW or Medicare. If the provider declines to submit the claim, you should obtain an itemized billing statement and forward it together with your identification numbers to BCBSUW for processing.
2. For medical benefits not submitted by the provider to BCBSUW, you must use a Major Medical claim form. You may obtain this form from BCBSUW. Save your itemized bills or statements for all covered medical SERVICES. All receipts or bills must be fully itemized. Cash register receipts, cancelled checks and balance due statements are not acceptable. Receipts and bills must be originals. **We do not accept photocopies.**
3. Be sure that all receipts and bills include: patient's name, patient's BCBSUW identification number, provider's name, provider's address, date(s) of service, diagnosis and diagnostic code, procedure code, CHARGE for each date of service, and is an official document from the provider. Be sure to use a separate claim form for each family member for each CALENDAR YEAR. After subtracting the DEDUCTIBLE and COINSURANCE, BCBSUW will process the balance of the CHARGES with payment made directly to you.
4. For SERVICES outside of Wisconsin, the HOSPITAL or PHYSICIAN can verify your BCBSUW coverage in out of state emergencies by calling toll free during regular working hours.
5. Payment is made for reasonable CHARGES incurred anywhere in the United States or Canada. BCBSUW will determine reasonable CHARGES for appropriate MEDICAL SERVICES or other items required while you are traveling in other countries. Obtain information on foreign currency exchange rates at the time CHARGES were incurred and an English language itemized billing to facilitate processing of your claim when you return home.
6. Blue Cross and Blue Shield Licensees participate in a program called "BlueCard". Whenever PARTICIPANTS access health care services outside the geographic area served by BCBSUW, the claims for those services may be processed through

BlueCard and presented to BCBSUW for payment in conformity with the network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when PARTICIPANTS receive BENEFITS within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), BCBSUW will remain responsible to the EMPLOYER for fulfilling all CONTRACT obligations. However, in accordance with any applicable BlueCard Policies, the Host Blue will only be responsible for providing such services as contracting with its participating providers and handling all interaction with its participating providers.

Even though the provider of SERVICES is located outside of Wisconsin, he/she may bill BCBSUW directly. If he/she bills you instead of BCBSUW, simply forward your itemized bill with your SUBSCRIBER identification number to the BCBSUW office at:

Blue Cross & Blue Shield United of Wisconsin

P. O. Box 2270

Fond du Lac, WI 54935

When you obtain health care SERVICES through BlueCard outside the geographic area we serve, the amount you pay for BENEFITS is calculated on the lower of:

- The billed charges for your BENEFITS, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specific group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a

specified group of providers. The price that reflects average savings may result in great variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

7. Statutes in a small number of states may require the Host Blue to use a basis for calculating SUBSCRIBER liability for BENEFITS that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate SUBSCRIBER liability calculation methods that differ from the usual BlueCard method noted above in paragraph six of this section or require a surcharge, we would then calculate your liability for any covered health care SERVICES in accordance with the applicable state statute in effect at the time you received your care.
8. Medicare eligible PARTICIPANTS should include a copy of Medicare's Explanation of Benefits along with the appropriate claim form and receipts. Claims may also be forwarded directly from Medicare to BCBSUW. To implement this service, contact BCBSUW for a Medicare crossover form.

F. Coordination of Benefits

The insurance industry has developed a standard policy provision called Coordination of Benefits (COB) which applies when there is duplicate coverage. Your health BENEFITS plan contains a Coordination of Benefits provision. When both husband and wife are working, members of the family are often covered by more than one group medical plan. COB provides that your BENEFITS will be "coordinated" with the BENEFITS to which you or one of your eligible DEPENDENTS may be entitled to receive from another group plan or any governmental program such as MEDICARE.

The purpose of this program is to allow you to receive up to 100% of covered medical expenses from all group plans combined - but no more. Individually underwritten medical policies (non-group) which are purchased with premiums paid entirely by you are not considered under this provision.

Under the COB provision, it is necessary to determine which group plan has the obligation to pay BENEFITS first. The group plan which pays first is called "primary". Other group plans are then considered "secondary" plans. A claim for BENEFITS is always submitted for consideration to the "primary" plan first; then the expenses along with the primary's plan's explanation of BENEFITS are submitted to the "secondary" plan.

Generally, the primary carrier is the plan identified first in the following sequence:

1. Your own plan.
2. Plan covering you as a DEPENDENT.
3. For a DEPENDENT child covered by both parents' plans, the plan of the parent whose birthday occurs earliest in the year. (For example, if the mother's birthday is in January and the father's is in September, the mother's plan would be primary.)
4. For laid off or retired persons, the plan which has been covering you the longest.

However, for DEPENDENT children whose parents are divorced or separated, the sequence of plans covering the child is:

1. The plan subscribed to by the parent who by court decree is responsible for insurance coverage.
2. The plan subscribed to by the parent who has custody.
3. The plan of the spouse of the custodial parent.
4. The non-custodial parent's plan.

G. Reasonable Charges

The Group Insurance Board has designed a health insurance CONTRACT which provides full payment of reasonable CHARGES for covered SERVICES. The CONTRACT requires that BCBSUW make a determination of and pay such CHARGES. (See the definition of "Charge" in the "Definitions" section.)

EMPLOYEES should note the following CONTRACT language:

General Conditions (cont.)

> "Nothwithstanding any other provisions of this AGREEMENT, BCBSUW will pay CHARGES as determined by BCBSUW . Disputes as to CHARGES will be referred, on a timely basis, to BCBSUW who will actively attempt to settle the dispute with the provider in a reasonable time frame. If no settlement is reached after such referral and a lawsuit is brought against a PARTICIPANT, BCBSUW will undertake the defense of such a suit for the PARTICIPANT or take such other measures as BCBSUW deems necessary to resolve the dispute. However, it is understood and agreed that BCBSUW will not undertake the defense of any such lawsuit or take any measures to protect the PARTICIPANT if the PARTICIPANT agrees to accept responsibility for any costs in excess of the CHARGES determined by BCBSUW.

While in the great majority of cases PHYSICIANS accept the BCBSUW payment as reasonable, an EMPLOYEE may on occasion be asked by the PHYSICIAN to agree verbally or to sign an agreement accepting the responsibility for any CHARGES in excess of those paid by BCBSUW. EMPLOYEES should understand that such a verbal or written agreement about fees with the provider will forfeit full protection under the CONTRACT.

CHARGES in excess of what BCBSUW has determined to be "reasonable" will appear on your Explanation of Benefits (EOB) statement.

If your PHYSICIAN or HOSPITAL bills you for any remaining balance in excess of the reasonable amount, you should:

1. Send all bills you may receive for balances above the reasonable payments made by BCBSUW to the BCBSUW office immediately. Continue sending BCBSUW all such bills you receive. This is the means by which BCBSUW is notified that you are continuing to be billed for the remaining balance.
2. Call BCBSUW immediately if you receive notice that such a balance has been referred for legal action or to a credit or collection agency.

You are not responsible for paying CHARGES in excess of what BCBSUW has determined as reasonable unless you have made an agreement with the service provider to accept this liability.

H. When Am I No Longer Eligible for Benefits?

When coverage terminates, BENEFITS will cease at the end of the period for which premiums were paid. However, (unless you have voluntarily cancelled your coverage or fail to pay premiums when due), BENEFITS will continue:

1. When confined in a GENERAL HOSPITAL or a SPECIALTY HOSPITAL - until discharge or until the maximum CONTRACT benefit has been provided, whichever occurs first.
2. Maternity BENEFITS (for the SUBSCRIBER, spouse or DEPENDENT daughter only) for 270 days after coverage ceases, provided your coverage was in effect 270 consecutive days before such termination.
3. SUBSCRIBERS who fail to continue coverage for the 36 month period provided by federal law are deemed to have canceled coverage. (See the brochure "It's Your Choice" for a description of this continuation of coverage provision.)

No refunds are made for premiums paid in advance unless the Group Insurance Board receives your written request on or before the last day of the month preceding the month for which you request the refund.

I. Subrogation

If you elect to be covered under this plan you agree that the Wisconsin Group Insurance Board shall be subrogated to you or your DEPENDENT'S rights to special damages for ILLNESS or INJURY caused by any act or omission of any third person to the extent that BENEFITS under the plan have been provided and further agree that such rights shall be and are assigned to the Wisconsin Group Insurance Board to such extent. Subrogation simply means that any medical payments provided by this plan become payment due to the BOARD if special damages are awarded.

BCBSUW will send the PARTICIPANT written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or non-payment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. The PARTICIPANT may contact the BCBSUW Customer Service department for more details of the decision.

If any PARTICIPANT has a problem or complaint relating to a benefit determination, he/she should contact BCBSUW. BCBSUW will assist the PARTICIPANT in trying to resolve the matter on an informal basis, and may initiate a Claim Review of the benefit determination. If the PARTICIPANT wishes, he/she may omit this step and immediately file a Formal GRIEVANCE.

CLAIM REVIEW:

A claim review may be done only when a review of denied BENEFITS is requested. When a claim review has been completed, and the decision is to uphold the denial of BENEFITS, the PARTICIPANT will receive written notification as to the specific reason(s) for the continued denial of BENEFITS and of his/her right to file a GRIEVANCE.

EXPEDITED GRIEVANCE:

Appeals related to an urgent health condition (i.e., life threatening), will be resolved within 72 hours of BCBSUW's receipt of the GRIEVANCE.

FORMAL GRIEVANCE:

To submit a GRIEVANCE, the PARTICIPANT (or the PARTICIPANT'S authorized representative) must submit it in writing to BCBSUW and identify it as a GRIEVANCE. In addition, the PARTICIPANT should also include the following information:

1. The date of service, the patient's name, amount and any other information such as claim number or health care provider, as shown on the denial; and

2. Any other pertinent information such as the identification number, patient's name, date and place of service, and reason for requesting review.

Except for an EXPEDITED GRIEVANCE, BCBSUW will acknowledge receipt of the GRIEVANCE within 5 business days of receipt. BCBSUW will inform the PARTICIPANT, in writing, of when the GRIEVANCE will be heard by the Grievance Committee at least seven (7) calendar days prior to the date of the meeting.

The PARTICIPANT (or the PARTICIPANT'S authorized representative) will have the right to appear in person before the grievance committee or by teleconference to present written or oral information. If the PARTICIPANT (or the PARTICIPANT'S authorized representative) chooses to participate in the GRIEVANCE Committee hearing, BCBSUW must be notified no less than four (4) business days prior to the date of the meeting.

BCBSUW will review the GRIEVANCE. BCBSUW will provide a written decision, including reasons, within 30 calendar days of receiving the GRIEVANCE. If special circumstances require a longer review period before the 30 calendar day period has expired, BCBSUW will notify the PARTICIPANT that an additional 30 calendar days will be needed to review the GRIEVANCE citing the reason additional time is needed and where resolution may be expected.

RIGHTS AFTER GRIEVANCE

There are potentially two avenues of further review available to the PARTICIPANT after BCBSUW's final GRIEVANCE decision.

1. Group Insurance Board Administrative Review Process

   (ETF Chapter 11, Wis. Administrative Code)

   BCBSUW's final GRIEVANCE decision may be reviewed by the Department of Employee Trust Funds provided the written request for the review is received by the Department within 60 days of the date the final GRIEVANCE decision letter is sent to the PARTICIPANT. Decisions not timely appealed to the Department are final. Send request to:

   Department of Employee Trust Funds
   ATTN: Quality Assurance Services Bureau
   801 West Badger Road
   P.O. Box 7931

Madison, WI 53707-7931

2. External Review by an Independent Review Organization

   ADVERSE DETERMINATIONS involving MEDICAL NECESSITY and EXPERIMENTAL/INVESTIGATIONAL determinations made by BCBSUW may be reviewed by an INDEPENDENT REVIEW ORGANIZATION. BCBSUW will send the PARTICIPANT a list of approved organizations at the time of BCBSUW's written decision regarding the GRIEVANCE. A copy can also be obtained by contacting BCBSUW's Customer Service department, logging onto www.bluecrosswisconsin.com or by contacting the Office of the Commissioner of Insurance.

To qualify for EXTERNAL REVIEW, the PARTICIPANT'S claim must involve one of the following:

1. An ADVERSE DETERMINATION involving MEDICAL NECESSITY, or
2. A determination that a treatment is EXPERIMENTAL/ INVESTIGATIONAL.

In either case, the treatment must cost more than $250 in order to qualify for EXTERNAL REVIEW.

If the PARTICIPANT wishes to pursue EXTERNAL REVIEW instead of a review by the Department of Employee Trust Funds, the PARTICIPANT or the PARTICIPANT'S authorized representative must notify BCBSUW's Appeal Department in writing at the following address:

Blue Cross and Blue Shield United of Wisconsin

Attn: Appeal Department

401 W. Michigan St., C10

Milwaukee, WI 53203

BCBSUW must receive the request within 4 months of the date of the PARTICIPANT'S GRIEVANCE decision letter. When the PARTICIPANT sends his or her request, the PARTICIPANT must indicate which INDEPENDENT REVIEW ORGANIZATION that he or she wants to use, and enclose a $25 check made payable to that organization.

After BCBSUW has received the PARTICIPANT'S request:

Claim Determination and Grievance Process (cont.)

1. BCBSUW will notify the INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds within 2 business days. Within 5 business days after receiving written notice of a request for independent review, BCBSUW will send the INDEPENDENT REVIEW ORGANIZATION copies of the information the PARTICIPANT submitted as part of his or her GRIEVANCE, copies of the contract, and copies of any other information BCBSUW relied on in the PARTICIPANT'S GRIEVANCE.
2. The INDEPENDENT REVIEW ORGANIZATION will review the submitted material and will request, generally within 5 business days, any additional information.
3. We will respond to any additional requests within 5 business days, or provide an explanation as to why such information cannot be provided.
4. Once the INDEPENDENT REVIEW ORGANIZATION has received all the necessary information, it will render a decision, typically within 30 business days.

There are certain circumstances in which the PARTICIPANT may be able to skip the GRIEVANCE process and proceed directly to EXTERNAL REVIEW. Those circumstances are as follows:

1. BCBSUW agrees to proceed directly to EXTERNAL REVIEW, or
2. The PARTICIPANT'S situation requires an EXPEDITED REVIEW.

If the PARTICIPANT'S situation requires an expedited review:

1. BCBSUW will notify the INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds within 1 day and send them the PARTICIPANT'S information.
2. The INDEPENDENT REVIEW ORGANIZATION has will review the material, normally within 2 business days, and will request additional information, if necessary. BCBSUW will have 2 business days to respond to this request.
3. Once the INDEPENDENT REVIEW ORGANIZATION has all the necessary information, it will render a decision, normally within 72 hours.

Claim Determination and Grievance Process (cont.)

If the INDEPENDENT REVIEW ORGANIZATION overturns BCBSUW's decision, the $25 the PARTICIPANT paid when requesting the review will be refunded. The decision of the INDEPENDENT REVIEW ORGANIZATION is binding to both BCBSUW and the PARTICIPANT as per contract. Once the INDEPENDENT REVIEW ORGANIZATION decision is issued, the PARTICIPANT has no further rights to review by the Department of Employee Trust Funds.

The PARTICIPANT cannot request a review of BCBSUW'S Final Appeal decision by both an INDEPENDENT REVIEW ORGANIZATION and the Department of Employee Trust Funds simultaneously. Once an INDEPENDENT REVIEW ORGANIZATION has begun the process to review a case, the DEPARTMENT will suspend its process. The INDEPENDENT REVIEW ORGANIZATION'S decision is binding on all parties and cannot be further appealed. If the INDEPENDENT REVIEW ORGANIZATION rejects the request for review of the ADVERSE DETERMINATION involving MEDICAL NECESSITY or EXPERIMENTAL TREATMENT denial on the ground of jurisdiction, then the DEPARTMENT will continue its process.

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Subject

PHARMACY BENEFIT MANAGER (PBM) SCHEDULE OF BENEFITS
STANDARD PLAN

The following description of the pharmacy benefit program is an excerpt from parts of Uniform Benefits that now apply to your prescription drug coverage. This is printed here for your convenience. A complete description of BENEFITS, exclusions and limitations can be found in your It's Your Choice book in Section D., III Benefits and Services D. Prescription Drugs coverage. Exclusions and Limitations are found likewise in Section D, under IV #10. All BENEFITS are paid according to the terms of Uniform Benefits.

All BENEFITS are paid according to the terms of the Master Contract between the PBM and Group Insurance Board. The Schedule of Benefits describes certain essential dollar limits of your coverage and certain rules, if any, you must follow to obtain covered SERVICES.

The Group Insurance Board has decided to utilize a PBM to provide prescription drug BENEFITS formerly provided directly by the Standard Plans. The PBM will be responsible for the prescription drug benefit as provided for under the pharmacy benefit terms and conditions of the Uniform Benefits. The prescription drug BENEFITS are dependent on your being insured under the State of Wisconsin group health insurance program.

The BENEFITS that are administered by the Pharmacy Benefit Manager (PBM) are subject to the following:

Prescription Drugs and Insulin:

Level 1* Copayment for Formulary Prescription Drugs: $5.00

Level 2** Copayment for Formulary Prescription Drugs: $15.00

Level 3 Copayment for Non-formulary Prescription Drugs:$35.00

*Level 1 consists of preferred generic and certain low cost brand name drugs.

**Level 2 consists of preferred brand name and certain higher cost generic drugs.

Annual Out-of-Pocket Maximum (Applies to Level 1 and Level 2 Prescription Drugs and Insulin): $1,000 per individual or $2,000 per family for Participants.

Pharmacy Benefit Manger (cont.)

NOTE: Level 3 copayments do not apply to the out-of-pocket maximum and must continue to be paid after the annual out-of-pocket maximum has been met.

Disposable Diabetic Supplies and Glucometers COINSURANCE: 20% per purchase, which will be applied to the Prescription Drug Annual Out-of-Pocket Maximum.

Smoking Cessation: One three-month course of pharmacotherapy covered per year.

BCBSUW, not the Pharmacy Benefit Manager (PBM), will be responsible for covering prescription drugs required to be administered during home care, office setting, confinement, emergency room visit or urgent care setting, if otherwise covered under the CONTRACT. However, prescriptions for covered drugs written during home care, office setting, confinement, emergency room visit or urgent care setting will be the responsibility of the PBM and payable as provided under the terms and conditions of the CONTRACT.

BCBSUW TELEPHONE NUMBERS AND ADDRESSES

Though we have tried to make this booklet as detailed as possible, you may still have questions about your coverage or membership. When you do, call, write or visit your Regional Service Center listed below.

Call toll free:

1-800-755-6400

TDD 1-800-656-6777

or
Write or Visit:

Blue Cross & Blue Shield United of Wisconsin
Southeastern Wisconsin Regional Service Center
1515 North RiverCenter Drive
Milwaukee, Wisconsin 53212
(414) 226-2233

Western Wisconsin Regional Service Center
2270 Highland Center
Eau Claire, Wisconsin 54701
(715) 836-7737

Northeastern Wisconsin Regional Service Center
145 South Pioneer Road
Fond du Lac, Wisconsin 54936
(920) 923-4141

The Department of Employee Trust Funds and Blue Cross and Blue Shield United of Wisconsin do not discriminate on the basis of disability in the provision of programs, services, or employment. If you are disabled and need this printed information in a different form or if you need assistance in using our services, please contact one of our Benefit Information or Customer Service offices.